



SOUTH DAKOTA BOARD OF NURSING  
4305 S. Louise Avenue Suite 201 ♦ Sioux Falls, SD 57106-3115  
(605) 362-2760 ♦ Fax: 362-2768 ♦ [www.nursing.sd.gov](http://www.nursing.sd.gov)

## Advanced Practice Nurse Licensure Renewal

To renew your license(s) all forms and fees must be postmarked by your expiration date or your license(s) will lapse. **You cannot work on a lapsed license(s)**, and are responsible to maintain licensure whether or not you receive a renewal notice.

Please follow instructions carefully to avoid delays in processing your renewal. If any information is incorrect, incomplete or illegible, processing may be delayed. Upon receipt of all forms and fees at the South Dakota Board of Nursing office your application will be considered for renewal. You will be notified in writing if additional information is required.

To renew your CNM, CNP, CRNA, or CNS (APN) license you must also be actively licensed as a Registered Nurse. SD is a compact RN state; for more information on compact states, see [www.ncsbn.org](http://www.ncsbn.org).

- If South Dakota is your primary state of residence, or if you reside in a non-compact state, you must renew your SD RN license to meet this requirement.
- If you reside in a Compact State, and your RN license in that state is active, provide a copy of your active multi-state compact RN license to be verified by the South Dakota Board of Nursing.

To renew your nursing license(s) **submit the following** to the South Dakota Board of Nursing office at the address listed above:

- Completed Application for Advanced Practice Nurse Renewal Form, pages 2-4
- Completed Verification of Employment Form, page 6
- Fee payment should be in the form of a money order or a personal check payable to South Dakota Board of Nursing. Fees are non-refundable and must accompany form. A \$20 fee will be charged for any insufficient check written.

Fees required to renew <u>both</u> South Dakota RN license and APN license:
\$90 RN renewal fee + \$70 APN renewal fee = <b>\$160</b>
Fees required to renew South Dakota APN license only (hold valid compact RN license with multi-state privileges):
\$70 APN renewal fee = <b>\$70</b>

To **Inactivate** your nursing license(s) complete and submit to the South Dakota Board of Nursing office:

- ☐ Inactivation request, page 5
- ☐ Fee payment



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## Application for Advanced Practice Nurse Renewal

I request to RENEW each South Dakota license checked:

- ☐ \*RN: License #(s): \_\_\_\_\_ ☐ CRNA: License #(s): \_\_\_\_\_  
☐ CNM: License #(s): \_\_\_\_\_ ☐ CNS: License #(s): \_\_\_\_\_  
☐ CNP: License #(s): \_\_\_\_\_

\*To practice as an APN in SD, you must hold both a RN license and an APN license. SD is a compact RN state; for more information on compact states, see [www.ncsbn.org](http://www.ncsbn.org).

**(Please Print)**

Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Other names previously used: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_  
Street/PO Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone: Home: ( ) \_\_\_\_\_ Other: ( ) \_\_\_\_\_ Email: \_\_\_\_\_

### Declaration of Primary State of Residence

I declare that my primary state of residence (where I hold a driver's license, pay taxes, and/or vote) is: \_\_\_\_\_ This is my "home state" under the [Nurse Licensure Compact](#) and is my "declared fixed permanent and principal home for legal purposes."

– OR –

I am employed by the federal government, and so am not affected by the Nurse Licensure Compact requirements regarding Primary State of Residence. Name of employer: \_\_\_\_\_

RN License # in primary state of residence if other than South Dakota: \_\_\_\_\_

### Collaborative Agreement Information (Applicable to CNM and CNP ONLY)

To perform the overlapping scope of advanced practice nursing and medical functions with a physician licensed in South Dakota as defined in SDCL [36-9A-12](#) and SDCL [36-9A-13](#), CNMs and CNPs must have on file a current Joint Board of Nursing and Medical and Osteopathic Examiners approved collaborative agreement (SDCL [36-9A-15](#) and SDCL [36-9A-17](#)).

Collaborative Agreement renewal is not required with licensure renewal, as long as the terms defined in the agreement describe current practice. The CNP/CNM is accountable to maintain current status of all collaborative agreements on file with the Boards. Once a collaborative agreement has been reviewed and approved by the Boards, it remains in effect until a new collaborative agreement has been submitted and approved. To obtain a collaborative agreement, go to the Board of Nursing website at [www.nursing.sd.gov](http://www.nursing.sd.gov), select Site Index then Collaborative Agreement.

- ☐ I do not have a collaborative agreement on file with the Boards. I do not perform the overlapping scope of advanced practice nursing and medical functions as defined in [36-9A-12](#) / [36-9A-13](#).  
☐ I have included a new or revised collaborative agreement with this application to be approved by the Boards.  
☐ I have an approved collaborative agreement(s) on file with the Boards. My **primary physician(s)** are listed below:

Primary Physician: \_\_\_\_\_

Primary Physician: \_\_\_\_\_



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### ***Certification Information***

Primary source verification of *current* certification from a Board-approved certification organization specific to your area of practice is *required* to be on file with the Board office prior to your APN license being renewed. If you are unsure if you have current certification on file, contact the Board office. Photocopies of certification documents are not accepted.

- ☐ Primary source verification showing evidence of my current certification is already on file with the BON office. If so, you do not need to resubmit.
- ☐ I am a CRNA, AANA# \_\_\_\_\_. Primary source verification of your re-certification status will be monitored on NBCRNA's verification website.
- ☐ I do not have primary source verification of my certification on file with the BON, I have sent the [Certification Verification Form](#) to my certifying organization to be sent to the SD BON verifying my on-going currency of certification.
  - ☐ CNPs or CNSs certified with NCC or ANCC must submit on-line requests to NCC and ANCC for primary source verification to be sent to the BON.
- ☐ I am exempt from the certification requirement. I was originally licensed as a CNP/CNM in South Dakota before June 26, 1996 or as a CNS before July 1, 1996 and have never submitted certification evidence to the Board for licensure purposes.

### ***Disciplinary Information***

1.	Have you ever been convicted, pled no contest/nolo contendere, pled guilty to, or been granted a deferred judgment or suspended imposition of sentence with respect to a felony, misdemeanor, or petty offense other than minor traffic violations? <b>If Yes, provide a signed and dated explanation. You must also submit copies of charges or citations and ALL communication with (to and from) the citing agency AND the court of jurisdiction, including evidence of completion/compliance with court requirements.</b>	<input type="checkbox"/> YES	<input type="checkbox"/> No
2.	Is there any pending criminal prosecution against you which would constitute a felony?	<input type="checkbox"/> YES	<input type="checkbox"/> No
3.	Are you currently being investigated or is disciplinary action pending against any professional license(s) or certificate(s) held by you?	<input type="checkbox"/> YES	<input type="checkbox"/> No
4.	Has any nursing license or certificate ever held by you in any state or country been denied, revoked, suspended, stipulated, placed on probation, or otherwise subjected to any type of disciplinary action?	<input type="checkbox"/> YES	<input type="checkbox"/> No
5.	Have you ever had privileges revoked, reduced, or otherwise restricted at any hospital or other healthcare provider entity?	<input type="checkbox"/> YES	<input type="checkbox"/> No
6.	Have you ever been subject to proceedings by a professional society to revoke, reduce, or restrict membership?	<input type="checkbox"/> YES	<input type="checkbox"/> No
7.	Have you ever been treated for abuse or misuse of any alcohol or chemical substance?	<input type="checkbox"/> YES	<input type="checkbox"/> No
8.	Have you ever experienced a physical, emotional, or mental condition that has endangered the health or safety of persons entrusted in your care?	<input type="checkbox"/> YES	<input type="checkbox"/> No
9.	Do you currently owe child support arrearages in the sum of \$1,000 or more?	<input type="checkbox"/> YES	<input type="checkbox"/> No

**For 2-9 above, provide an explanation for each Yes response on a separate piece of paper, with a complete description of dates and circumstances. You must also send ALL supporting applicable documents.**

**Employment Information:** Select **ONE** response in each category below that best represents your current practice.

<b>Employment Status:</b> <input type="checkbox"/> Full-time Nurse <input type="checkbox"/> Part-time Nurse <input type="checkbox"/> Full-time other than Nursing <input type="checkbox"/> Part-time other than Nursing <input type="checkbox"/> Volunteer Nurse <input type="checkbox"/> Unemployed <input type="checkbox"/> Retired	<b>Where Presently Employed:</b> County: State: City: Zip Code:	<b>Type of Position:</b> <input type="checkbox"/> Nurse Management <input type="checkbox"/> Consultant <input type="checkbox"/> Case Manager <input type="checkbox"/> Nursing Program Faculty <input type="checkbox"/> Clinic Nurse <input type="checkbox"/> Staff Nurse <input type="checkbox"/> Charge Nurse <input type="checkbox"/> Inservice Educator/Staff Development <input type="checkbox"/> Advanced Practice Nurse <input type="checkbox"/> CNM <input type="checkbox"/> CNP <input type="checkbox"/> CRNA <input type="checkbox"/> CNS <input type="checkbox"/> Other
	<b>Highest Degree Held:</b> <input type="checkbox"/> Diploma / Registered Nurse <input type="checkbox"/> Associate Degree/RN <input type="checkbox"/> Baccalaureate Degree/RN <input type="checkbox"/> Baccalaureate in other field <input type="checkbox"/> Masters in Nursing <input type="checkbox"/> Masters in other field <input type="checkbox"/> Doctorate (PhD, Ed, DNP) <input type="checkbox"/> Practical Nurse Diploma/A.D.	
<b>Principle Field/Place of Employment:</b> <input type="checkbox"/> Hospital <input type="checkbox"/> Nursing Home/Long Term Care <input type="checkbox"/> Nursing Education Program <input type="checkbox"/> Home Health / Hospice <input type="checkbox"/> School <input type="checkbox"/> Outpatient Surgical Center <input type="checkbox"/> Office / Clinic <input type="checkbox"/> Community Health <input type="checkbox"/> Self-Employed <input type="checkbox"/> Other	<b>Formal Education Activities:</b> <input type="checkbox"/> I am NOT taking courses toward an advanced degree in nursing <input type="checkbox"/> I am currently taking courses toward an advanced degree in nursing	

**What percent of your current position involves direct patient care?**

☐ 0%                      ☐ 25%                      ☐ 50%                      ☐ 75%                      ☐ 100%

**Do you intend to leave/retire from nursing practice in the next 5 years?**    ☐ YES    ☐ NO

**States other than South Dakota in which you are licensed as a nurse:**

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### Affidavit

I, the undersigned, declare and affirm under the penalties of perjury that this application for licensure in the state of South Dakota has been examined by me, and to the best of my knowledge and belief, is in all things true and correct.

**Signature of Applicant** \_\_\_\_\_ **Date** \_\_\_\_\_



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I **DO NOT** wish to renew my license and request to **INACTIVATE** each South Dakota license checked:

- |                                                   |                                                    |
|---------------------------------------------------|----------------------------------------------------|
| <input type="checkbox"/> RN: License #(s): _____  | <input type="checkbox"/> CRNA: License #(s): _____ |
| <input type="checkbox"/> CNM: License #(s): _____ | <input type="checkbox"/> CNS: License #(s): _____  |
| <input type="checkbox"/> CNP: License #(s): _____ |                                                    |

**(Please Print)**

Name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Address: \_\_\_\_\_  
Street/PO Box \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone: Home: (\_\_\_\_) \_\_\_\_\_ Other: (\_\_\_\_) \_\_\_\_\_ Email: \_\_\_\_\_

Fee required to inactivate **each** South Dakota license requested is = **\$10**

**Fee payment** should be in the form of a money order or a personal check payable to South Dakota Board of Nursing. Fees are non-refundable and must accompany form. A \$20 fee will be charged for any insufficient check written.

**Sign, date and return this form with Inactivation fee.**

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

(7/08)



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## VERIFICATION OF EMPLOYMENT

Applicant: Complete the top section of this form then forward to your employer or former employer. This form may be duplicated for additional employment verifications. Return completed form(s) to the South Dakota Board of Nursing.

To obtain/retain active licensure, a nurse must provide verification of a minimum of 140 hours in a 12-month period OR 480 hours in six years of employment/volunteer work in nursing.

**Please Print**

Name, First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

☐ I have been employed/volunteered as a nurse (LPN, RN, CRNA, CNM, CNP, or CNS).

☐ I have not been employed as a nurse within the last six years.

I hereby request and authorize my employer/former employer to release the information requested on this form to the South Dakota Board of Nursing for Licensure purposes.

Signature of Applicant \_\_\_\_\_

Date \_\_\_\_\_

**This Section to be Completed by Employer  
(Provide Employment Hours Within the Last 6 Years)  
Note: This section Cannot be Signed by the Applicant**

The above-named individual (was) employed/volunteered as a nurse

**From** \_\_\_\_\_  
Month/Date/Year

**To** \_\_\_\_\_  
Month/Date/Year

**Total hours worked in this period:** \_\_\_\_\_

I the undersigned declare and affirm that, according to our records and to the best of my knowledge and belief, the information provided above for purpose of licensure is true and correct.

Signature of Agency Representative/Title \_\_\_\_\_

Date \_\_\_\_\_

Who can verify/confirm number of hours employed/volunteered

Name of Employer: \_\_\_\_\_

Address of Employer: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

## CERTIFICATION VERIFICATION FORM

**Complete items 1 – 8 on this form then forward to certification organization.**

**Please Print**

1. Name, First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_
2. Other names previously used: \_\_\_\_\_
3. Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Street/PO Box
4. Name of Certification Organization \_\_\_\_\_
5. Certification # \_\_\_\_\_ Expiration Date \_\_\_\_\_
6. Certification status (check one):      Initial certification verification      Recertification verification
7. Certification type (check one):      CRNA      CNS      CNM      CNP
8. Consent to *Release Information* to the South Dakota Board of Nursing:

I authorize the above named certification organization to disclose information regarding the identification, evaluation, and certification of the above named applicant that is maintained by the above named certification organization to the South Dakota Board of Nursing. I authorize the South Dakota Board of Nursing to utilize this information as needed for validation, investigation, litigation, discipline, or agreements concerning my nursing license. This authorization to release requested information shall expire at my written request. A copy of this request shall be as effective as the original.

Applicant Signature

Date \_\_\_\_\_

**Certification Organization:** complete below then forward to South Dakota Board of Nursing at address above.

NAME OF CERTIFICATION ORGANIZATION_____		
Certification # _____	<b>Date of Current Certification Maintenance Cycle/Recertified through:</b> _____	
Certification type:      CNM            CRNA   CNS– specialty area_____  CNP– specialty area_____		
Is certification current? YES  NO (Please explain on a separate paper)	Has certification lapsed? YES ( Please explain on a separate paper) NO	
Has certification been revoked? YES (Please explain on a separate paper) NO	Is certification provisional/conditional in any manner? YES (Please explain on a separate paper) NO	
<div style="text-align: center;">/</div> Name/Signature of person completing form                          Title                          Date		